the high incidence of aneurysms of the coronary arteries, extreme thrombocytosis and myocardial infarction during the recovery period, aspirin therapy in conventional doses was continued for two months after onset of the disease. All patients in this series recovered completely.

Kato and associates in Japan have also studied the effect of treatment of MLNS by means of coronary angiography during the recovery phase of the illness. Although they were apparently unaware of the need for high-dose therapy during the acute phase, they were able to show a definite reduction in frequency of coronary aneurysms in patients on prolonged aspirin therapy.

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Acral Lentiginous Melanoma

ACRAL LENTIGINOUS MELANOMA (ALM) is a relatively recent addition to the clinicohistopathologic classification of melanomas. Clark and co-workers in 1975 and Reed in 1976 developed the concept of this variant to describe lesions characterized by lentiginous macules occurring on the palms, soles and subungual areas. Traditionally, the three variants of cutaneous melanoma are categorized as lentigo maligna melanoma (LMM), superficial spreading melanoma (SSM) and nodular melanoma (NM). ALM represents a fourth group and is reported to constitute 7 percent to 9 percent of all melanomas.

Clinically, ALM resembles LMM in that the lesions are frequently macular, may be irregular in shape and may show variation in pigmentation. In contrast to LMM, these lesions usually do not occur in sun-exposed areas of the skin and are distributed in regions that are free of hair.

Both sexes are at equal risk for the development of ALM. The age at onset is usually in the third through sixth decades, which is similar to the onset of SSM and NM. Although relatively uncommon in whites, ALM may account for up to 50 percent of melanomas occurring in blacks.

Histologically, ALM may appear to be innocuous in the radial growth phase, demonstrating only a diffuse hyperplasia of melanocytes in the basal epidermal layer. The melanocytes may range in character from benign-appearing spindled or epithelioid cells to bizarre and dysplastic cells. There is usually an absence of epidermal atrophy and dermal actinic damage in ALM, both prominent features of LMM. In the vertical growth phase, desmoplasia (not an uncommon feature of LMM) is also observed in ALM.

It is essential to obtain a biopsy specimen of a suspected ALM, and an in toto excision is preferable as there may be a gradation of melanocytic dysplasia from the periphery to the central portion, with some areas showing only minimal cellular atypia.

Treatment of digital ALM is by "ray amputation," which includes the entire digit plus the distal portion of the corresponding metatarsal or metacarpal bone. Lesions of the thumb may be treated by disarticulation of the metacarpophalangeal joint, which allows for subsequent reconstruction and, therefore, maintenance of apposition. Volar lesions are best removed by wide excision.

The mechanism of spread of ALM is not yet adequately described. At present, there are insufficient statistical data available on aspects such as the level and depth of invasion, mitotic activity and host response to propose definite indications for lymph node dissection, and similarly, more sophisticated forms of management of these lesions.

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Newer Aspects of the Use of Anthralin in Psoriasis

ANTHRALIN IS AN effective agent in the treatment of psoriatic lesions in patients in hospitals or day care centers. It is administered in concentrations of 0.1 percent to 1.0 percent in a hard or soft paste and may be used in combination with topically administered tars or steroids, and ultraviolet light. Clearing can be expected in 10 to 28 days. A pomade containing anthralin 0.1 percent to 1.0 percent can produce excellent results in psoriasis of the scalp. The method of action of anthralin is not yet clear; however, it is known to bind to DNA in vitro, and presumably inhibits DNA synthesis.

The major problems that prevent more successful and widespread use of standard anthralin regi-

mens for outpatients are the following: (1) Burning of normal skin by higher concentrations necessitates careful application of the stiff paste on the lesions by a skilled nursing staff; (2) anthralin can stain bedclothes and sheets, making home use difficult; (3) prolonged applications are sometimes needed; (4) anthralin should not be used in skin folds, and (5) if anthralin inadvertently gets in the eyes, severe burning may result. These problems have been partially overcome by the newer methods of application discussed below.

Schaefer and co-workers used 1 percent anthralin with 1 percent salicylic acid in petrolatum, which they applied to the psoriatic lesions each day; the ointment was left on for one hour and then removed with soap and water. As far as possible, the anthralin should not be placed on normal appearing skin because this may cause erythema and a burning sensation. It is preferable to follow each treatment with application of an emollient ointment or cream. If this regimen is continued daily, it is successful in clearing 30 percent of the psoriatic lesions and improving an additional 50 percent. The advantage of this method is its short application time, which allows a patient to use anthralin while relaxing at home and avoids staining clothes and sheets. The chief disadvantage is occasional burning that may occur around treated plaques.

In Sweden, Brody and Johansson used 0.01 percent to 0.03 percent anthralin with 10 percent salicylic acid in petrolatum on a daily basis. This ointment does not need to be so carefully applied to lesions only, as burning of normal skin is rarely seen. It usually does not stain clothing so the ointment may be applied in the evening and morning. The main disadvantage is the slow response of lesions, which may take up to three months to resolve.

In England, Seville and co-workers compared the use of 0.25 percent anthralin in a cream base (Dithrocream; dithranol is the generic name) with 0.25 percent anthralin in an ointment base. He found the two preparations to be equally effective. However, patients preferred the easier application of the cream base although it caused more staining than the ointment base.

Anthralin continues to be an important agent in the inhospital treatment of patients with psoriasis. Newer methods of application are making its use possible to outpatients as well.

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Lymphomatoid Papulosis

THE CLINICAL AND HISTOLOGICAL assessment of patients with atypical infiltrates suggestive of lymphoma or leukemia but confined only to the skin has been a difficult problem for many years. In some of these patients involvement of other organs occurs within a short time and a definite diagnosis can be made. In others, however, crops of lesions may continue to develop for many years. These lesions spontaneously resolve within a few weeks and are accompanied by no other evidence of neoplastic disease. The term lymphomatoid papulosis, proposed by Macaulay in 1978, has been the most popular designation for this latter group.

The most common clinical pattern is an inflammatory papular or papulonecrotic eruption that is indistinguishable from pityriasis lichenoides acuta (Mucha-Habermann disease). Mycosis fungoides may be difficult to exclude but clinical evidence of small, short-lived papulonecrotic lesions as well as histological evidence of hemorrhage and epidermal necrosis are said to favor a diagnosis of lymphomatoid papulosis. The relationship of lymphomatoid papulosis to pityriasis lichenoides and, indeed, the nature of pityriasis lichenoides, both remain unclear. It is interesting that in some patients with this clinical pattern the condition responds favorably to ultraviolet light exposure.

Clinical diagnosis is made even more difficult by the fact that some of these patients have papular, plaque-type or nodular lesions that do not resemble pityriasis lichenoides. These lesions generally show less clinical and histological evidence of inflammation and are more suggestive of the tumors of mycosis fungoides or other lymphomas, but still may wax and wane for many years.

Although the great majority of patients reported in the literature have experienced a prolonged benign course, there have been at least three cases in which visceral lymphoma developed and one that has evolved into the more usual pattern of